

Impressions of Soviet Psychiatry

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MY OVER-ALL IMPRESSION of psychiatry in the Soviet Union, based on a month-long visit there in the summer of 1959, is that it is an eclectic discipline, making use of a wide range of techniques. It is essentially conservative and middle-of-the-road. It has, on one hand, abandoned such radical surgical procedures as prefrontal lobotomies, and, at the other end of the spectrum, it also rejects psychoanalysis as we practice it in this country.

It occupies a relatively modest place in the total practice of medicine in the Soviet Union. One measure of this is the fact that there is less than one hospital bed for mentally ill patients per 1,000 population there, compared with the ratio here in California of 2.3 public beds per thousand, plus a considerable number of beds in private hospitals. This does not necessarily mean that there is less mental illness there than here, and it certainly does not mean that the Russians are less concerned than we are about meeting the health needs of the people. Indeed, they are very advanced and very aggressive in this respect. It does mean that they tend to treat emotionally disturbed persons on an outpatient basis as much as possible. It means, too, that the practice of psychiatry has neither the depth nor the scope there that it has in this country.

Like every other scientific discipline in the Soviet Union, psychiatry takes its cue from the prevailing political philosophy. The validity of all scientific findings is gauged by whether or not they are compatible with Marxism. It is within this context that the Freudian orientation is unconditionally rejected; it is considered inimical to Marxism. It is also within this context of political acceptability that the Pavlovian neurophysiological approach is the all-embracing one in Soviet psychiatry. Its materialist and mechanistic orientation is consistent with Marxian goals.

The types of problems presented to the psychiatrist in this country are considered by the Russians to be typically decadent and bourgeois. The concern for personal fulfillment, the emphasis on meeting the emotional needs of the individual, the probing into the unconscious to identify and clarify emo-

• Psychiatry in the Soviet Union is essentially conservative, middle-of-the-road and eclectic. It rejects both extremes: radical surgical treatment such as prefrontal lobotomy, and Freudian psychoanalysis. It is Pavlovian and neurophysiological in its orientation and closely linked to Marxian philosophy; most personal problems are believed to be sociocultural in origin, and they are expected to diminish as the country moves closer toward its political and economic goals, making psychiatry progressively more circumscribed in its applications.

The varieties of therapy include work therapy, aimed toward returning patients to society quickly and productively; electrosleep therapy and electroconvulsive therapy, both of which seem to be falling into disrepute; insulin-coma therapy, widely used in psychosis; hunger therapy; pharmacotherapy similar to our own but lacking in the large numbers of drugs we use; tissue therapy; psychotherapy, of limited depth and chiefly concerned with the rational, conscious elements in the patient's life.

tional conflicts—such considerations are alien to Soviet psychiatrists.

Essentially, their belief is that the problems of the individual are primarily socio-economic and environmental in nature. Many such problems are dealt with by agencies such as trade unions and Young Pioneers, which concern themselves with many of the kinds of problems that social workers handle in this country. Social workers as a professional entity are nonexistent in the Soviet Union.

It is believed there that as the country continues to make progress in achieving its Marxist goals, the problems of the mentally ill patient will no longer present themselves and that the practice of psychiatry will in due course wither away. Meanwhile, emphasis in psychotherapy is on integrating the individual within the social fabric, rather than on achieving self-understanding.

The cornerstone of Soviet psychiatry is the Pavlovian approach, which is concerned with the functioning of the cortex as the control center and the consciously thinking element of the brain. Function is interpreted in terms of stimulation-inhibition systems. Malfunction is explained primarily by imbalance or conflict between the dynamics of stimulation and inhibition. Treatment consists of restoring this balance in neurophysiological terms.

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Behavior is described in terms of unconditioned reflexes, which are innate; conditioned reflexes, which are learned patterns acquired through the developmental phases; and, in effect, a second layer of conditioned reflexes which are derived from and are dependent upon those originally learned. This concept binds all activity into a complex, interconnected neurophysiological pattern.

Given this orientation, the Soviet psychiatrist tends to deal with his patient in terms of the conscious, rational elements of his life situation. He persuades rather than probes, and tries to provide guidance rather than produce insight.

How does this philosophical and scientific orientation manifest itself in specific therapy? Some types of therapy I observed were eminently rational and directly reflected the Pavlovian approach. Others were almost metaphysical, somewhat bizarre, and, I must admit, highly provocative of thought in a student of psychiatry. Like most eclectic disciplines, Soviet psychiatry tends to be pragmatic and expedient. Like the practice of psychiatry elsewhere, it manifests inconsistencies and conflicts.

At the Bechterev Institute in Leningrad, I observed an impressive demonstration of work therapy. Here in a group of factory-like shops, both inpatients and outpatients spend a portion of each day at productive work.

The work that was being performed included the manufacture of fountain pens, buttons, hammocks, gymnasium equipment, fabric and furniture. The shops are well equipped and the work is supervised by technical experts who set and maintain high standards of proficiency. Products made in these workshops are sold to the general public through stores, and proceeds are spent to purchase new equipment for Bechterev and to pay for repairs.

The patient in work therapy is encouraged to continue with work of the type he was doing before he became ill, and the aim of the program is to return him as soon as possible to his productive function within the social organization. This aim directly reflects the Marxist orientation of the program.

There is recognition of the need for vocational retraining of some patients, particularly those with brain damage. This also is provided by the program.

Each patient is encouraged to work at his full capacity. The length of work day and complexity of the tasks are increased as the patients give evidence of improvement. The climate within the workshops is kept as free as possible from tension and stress, but the approach to the work is earnest and realistic—in decided contrast to the indulgent, “make-work” atmosphere which tends to characterize many occupational therapy programs in this country.

The technical supervisors in the workshops function under the direction of the psychiatric staff, which holds regular psychotherapeutic sessions with the patients, either on a group basis or individually. These sessions are devoted primarily to explanation, suggestions, guidance and advice with respect to work performance and work relationships. Psychiatrists also make daily rounds to observe the patients in the workshops.

In evaluating such a program, one must keep in mind that it is directly linked to the basic Marxian concept of work and its social usefulness. In a communistic society work is the central core of life. The dedicated attitude the individual worker has toward maintaining his status in the social organization through work infuses the work therapy program with a vitality which would be difficult to match in this country.

Yet, even in our individualistic society, people derive their satisfactions and their sense of identity, to a large extent, in terms of the constructive work they do. Work tends to deepen one's feelings of adequacy and helps overcome feelings of helplessness. Although I doubt that work as therapy in this country could ever be as all-enveloping as it is in the Soviet Union, there is a good deal to be learned from the Soviet program. I share their belief that a patient should suffer as little disarticulation from his work life as possible during treatment. The Russian goal of speeding the patient back to his normal pattern of work is one we might emulate.

In pronounced contrast to the reality-oriented program of work therapy was the almost mystical treatment I observed at Sochi. Sochi is one of a group of semitropical cities on the Black Sea coast that has been converted into “factories of health” for everyone.

Almost all “vacationers” as well as convalescents receive regular treatment at the palatial Sochi spa, an impressive marble structure that looks more like a Greco-Roman temple than a medical facility. Sochi is celebrated for the curative power of its sulphur springs. The sulphur-laden water is piped into the building to be used for an almost endless repertory of sulphur treatments, which are available for neurotic patients as well as those with somatic illnesses. The Soviet physicians who accompanied me persuaded me to sample several of the treatments, and insisted that sulphur had specific therapeutic value for neurosis. My impression was that the highly organized, hypnotically suggestive rites associated with the treatment was the main curative ingredient. I felt sure that tens of thousands of occult neurotics were kept in adequate compensation yearly in these sanitarium cities. Such patients, incidentally, do not show up in the official statistics on mental illness,

which suggests that for comparative purposes those statistics are of doubtful value.

Sleep therapy has been widely used in the Soviet Union, although I was given to understand that it is now falling into some disrepute. This treatment, which is quite different from electronarcosis as practiced in this country, induces sleep for a period ranging from ten to sixty days. Sleep is achieved through a sustained electric current which produces a protective cortical inhibition. The treatment is used for manic-depressive and schizophrenic patients and for those in acute anxiety states. The patient can be awakened for the intake of food and for meeting other physical needs, and returned to the sleep state simply by the removal and reapplication of the current. This treatment apparently provides temporary relief from acutely disturbing thoughts, sensations and feelings, probably thereby allowing a reconstitution of ego defenses, although such an explanation as this would not be acceptable to the Pavlovians.

Both insulin and electroconvulsive therapy are used in the Soviet Union, although the Russian psychiatrists' evaluation of these two treatments is different from ours. They use insulin-coma treatment extensively in the treatment of schizophrenic patients, with few reservations. In this country, on the other hand, insulin treatment is becoming less widely used because of the adverse side effects, the possible dangers and the time and expense involved.

Electroconvulsive therapy is currently in growing disfavor among Soviet psychiatrists. They believe that this treatment causes brain damage. Professor Fedotov, chief of the Institute of Psychiatry in Moscow, documented this thesis by demonstrating to me the brain damage produced in small animals by the use of electric currents. However, I believe that the experience we have had in this country with electroconvulsive therapy warrants its continued inclusion in our armamentarium, since brain damage in human material is considered by us as the unusual rather than the common occurrence. True, electroconvulsive therapy is sometimes used unwisely, and this indiscriminate use has reflected adversely on its reputation. But used in properly selected cases, and properly administered with the support of excellent muscle-relaxants which are now available, it is a sound and effective form of therapy.

Drugs are very widely used in Soviet psychiatric practice. They fit very properly within the Pavlovian orientation, since their action is organic. The Russian drugs are essentially the same as ours. The ones most widely used are aminazine (which is like chlorpromazine), reserpine and amphetamine. I saw nothing there comparable to meprobamate. Without the thrust of a highly competitive pharma-

ceutical industry, the Soviet Union does not have our great proliferation of each type of drug. This has both advantages and disadvantages. There it is possible to accumulate enough clinical data on each drug, through exhaustive and unvaried use, to yield significant conclusions. Here, we are under such promotional pressure to try out a new variation that we often virtually abandon good drugs before we have really tested their value to the limits. It sometimes seems that the staying power of a drug in this country is positively correlated with the size of its promotional budget rather than with its demonstrated effectiveness. On the other hand, out of the endless variations that are presented to us, we often encounter modifications that, although structurally minor, produce clinical significantly different results. This experience with a great range of derivatives is not available to our colleagues in the Soviet Union.

Drastic psychosurgery such as prefrontal lobotomy has been officially abolished in the Soviet Union since 1950. It has been denounced as a destructive procedure and contrary to the Pavlovian theory of protective inhibition. The position there is that in schizophrenia the cells are in a prolonged state of inhibition and do not function, but that there is always the possibility of recovery. Once the surgeon's knife has removed the cells, even that remote possibility is gone. Personally, I cannot quarrel with that point of view.

Hypnosis is in good repute in the Soviet Union. Since it functions through the mechanism of cortical inhibition, it is compatible with the Pavlovian approach. Although I encountered relatively little direct evidence of its use, I understand that some very rewarding research is being carried on there in the use of hypnotism in obstetrics, dentistry and anesthesia, and as an adjunct to psychotherapy.

One of the strangest techniques I encountered was the use of hunger therapy. This method, I was informed, was especially applicable to schizophrenics and severe depressive reactions, but contraindicated where much agitation was present. The patient is given no food at all for 30 days. The intake of water is also restricted. Vitamins and bicarbonates are provided to prevent severe nutritional deficiency syndromes and acidosis. During this period, the patient is very carefully watched medically. Blood chemical studies and urinalysis are done regularly. Every precaution is taken to make sure that the patient is undergoing no threatening physiological changes. After the 30-day period, the intake of food is gradually increased. This goes on for another 30-day period, at the end of which the patient has been restored to his normal intake.

I will have to admit that, except for its obvious effectiveness in dealing temporarily with obesity, I

fail to discern what therapeutic purpose is served. In most cases, depriving a person of food strikes a blow at his survival strivings. This treatment must certainly be construed unconsciously by patients as highly punitive, and if they improve as the result of it, it is probably because they have become restituted with the punitive demands of their own consciences.

Few therapeutic innovations in the Soviet Union challenged my imagination as vividly as did tissue therapy. I am in no position to validate for you the effectiveness of this concept, but I would like to report what I learned through my discussions with Dr. Filatova, widow of academician Vladimir Filatov, founder of the theory. Filatov was an ophthalmologist, and his theory of tissue therapy was evolved as the result of his work with corneal transplantation. To sum it up briefly, he discovered that such transplants were more effective when he took the cornea from the eye of a corpse and kept it in cold storage for several days, than when he worked with a fresh corneal graft taken from a living donor. Stimulated by this phenomenon, he undertook extensive investigations which led him to the hypothesis that all living material, both animal and vegetable, if maintained under conditions which are unfavorable but not lethal, responds by generating certain substances which he called biogenic stimulators, and that these substances are capable of stimulating the vital processes in an organism into which they have been introduced.

He attributed to biogenic stimulators a number of properties, such as deterring inflammatory and degenerative processes and intensifying the secretion of gastric juice and the formation of antibodies. On the basis of extended though inconclusive studies of the chemical nature of these stimulators, he suggested that their fundamental action was probably to increase the activity of enzymes of the body and consequently to improve metabolism.

Accordingly, Filatov concluded that tissue itself, under the proper circumstances, had enormous therapeutic capacities—that it could generate great adaptive powers within any organism. He used tissue in several forms—either segments of preserved tissue implanted surgically or tissue extract given by injection or orally.

At the Filatov Institute in Odessa, Dr. Filatova showed me a map which indicated widespread current research in tissue therapy. Between 1933, when Filatov started to work with tissue therapy, and his death in 1956, he had a series of fantastically successful experiences with it within his own specialty. Colleagues of his, according to his reports, were equally successful in treating skin lesions of various kinds, bronchial asthma, ulcers, tuberculosis, leprosy and venereal diseases. In addition—and this, of

course, was of special interest to me—he reported favorable experience in treating two patients with advanced schizophrenia through tissue therapy, and cited similar results as having been reported by several Russian psychiatrists, including Lastovetsky, Shpak, Kopeliovich and Maslov.

I have touched on a number of somatic therapies used in the Soviet Union, but I do not wish to give the impression that these methods overshadow psychotherapy, which is becoming increasingly widely used there. Nor do I wish to suggest that psychotherapy in that culture is limited solely to a back-to-work movement. Despite the basic Pavlovian orientation, many diverse elements find their way into Soviet psychotherapy. There are now specialists who devote their entire professional time to a type of psychotherapy which is dynamically oriented. Professor V. N. Myasishchev, director of the Bechterev Institute, carries on such a practice, I am told.

These psychiatrists, although they do not seek a sexual basis for all behavior problems, do probe deeply into the patient's past for the psychogenesis of personality disorders. They search out obscure and concealed sources in experiences of childhood which might illuminate current symptoms. Their concern with the social integration of the patient has not completely obliterated their recognition of highly individual and personal emotional problems in the field of marital and familial relationships, and their psychotherapeutic methods of dealing with such problems are not unlike ours.

To sum up my impressions of Soviet psychiatry, I feel that its rigid adherence to Pavlov's orientation is a limiting factor, and that its subservience to the prevailing political philosophy is a grave hazard. On the other hand, the general willingness to try new techniques, such as those I have described today, indicates a vitality within the discipline. There is certainly much that is commendable about the reality-oriented approach of such treatments as work therapy.

From my point of view, the arbitrary rejection of Freud on the part of Soviet psychiatry creates a serious communications barrier between us and them. And yet, since most psychiatrists in this country are also fundamentally eclectic in their approach, the barrier is far from insurmountable.

On the basis of the month that I spent behind the Iron Curtain, I feel that psychiatrists on both sides of the curtain have a great deal to contribute to each other through an interested and alert exchange of ideas, approaches, experiences and findings. It is such interchange, no matter how baffling the barriers, that psychiatry—and indeed all of medicine—must seek, for our own strength and for the sake of the people we serve.

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